**Senate File 558 - Introduced**

SENATE FILE 558
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## A BILL FOR

An Act relating to Medicaid program improvements, making an appropriation, and providing penalties.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

MEDICAID LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— PROVISION OF CONFLICT-FREE SERVICES

Section 1. MEDICAID LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— PROVISION OF CONFLICT-FREE SERVICES. The department of health and human services shall adopt rules pursuant to chapter 17A to ensure that services are provided under the Medicaid program to members of the long-term services and supports population in a conflict-free manner. Specifically, case management services shall be provided by independent providers and supports intensity scale assessments shall be performed by independent assessors.

DIVISION II

LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— OPTION FOR FEE-FOR-SERVICE PROGRAM ADMINISTRATION

Sec. 2. LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— OPTION FOR FEE-FOR-SERVICE PROGRAM ADMINISTRATION. The department of health and human services shall require each Medicaid managed care organization with whom the department executes a contract to administer the Iowa high-quality health care initiative as established by the department, to provide the option to Medicaid long-term services and supports population members to enroll in or transition to fee-for-service Medicaid program administration rather than managed care administration. The department shall amend any contract, request any Medicaid state plan amendment, and adopt rules pursuant to chapter 17A, as necessary, to administer this section. The rules shall include the process for transitioning a current Medicaid long-term services and supports population member to fee-for-service program administration.

DIVISION III

LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— POLICY FOR DENIAL OF CARE

Sec. 3. LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— POLICY FOR DENIAL OF CARE. The department of health and human

services shall require each Medicaid managed care organization with whom the department executes a contract under the Medicaid program to maintain an authorized member's Medicaid long-term services and supports unless the member's health care provider determines a change in the long-term services and supports is medically necessary. The inability of a member who is authorized for long-term services and supports to utilize all approved service hours, including respite care, shall not result in a reduction in authorized services unless there is medical evidence that the services are medically unnecessary for the member.

DIVISION IV

MEDICAID WORKFORCE PROGRAM

Sec. 4. WORKFORCE RECRUITMENT, RETENTION, AND TRAINING PROGRAMS. The department of health and human services shall contractually require any managed care organization with whom the department executes a contract under the Medicaid program to collaborate with the department and stakeholders to develop and administer a workforce recruitment, retention, and training program to provide adequate access to appropriate services, including but not limited to services to older Iowans. The department shall ensure that any program developed is administered in a coordinated and collaborative manner across all contracting managed care organizations and shall require the managed care organizations to submit quarterly progress and outcomes reports to the department.

DIVISION V

PROVIDER APPEALS PROCESS —— EXTERNAL REVIEW

Sec. 5. MEDICAID MANAGED CARE ORGANIZATION APPEALS PROCESS —— EXTERNAL REVIEW —— PENALTY.

1. a. A Medicaid managed care organization under contract with the department of health and human services shall include in any written response to a Medicaid provider under contract with the managed care organization that reflects a final adverse determination of the managed care organization's internal appeal process relative to an appeal filed by the Medicaid provider, all

of the following:

(1) A statement that the Medicaid provider's internal appeal rights within the managed care organization have been exhausted.

(2) A statement that the Medicaid provider is entitled to an external independent third-party review pursuant to this section.

(3) The requirements for requesting an external independent third-party review.

b. If a managed care organization's written response does not comply with the requirements of paragraph "a", the managed care organization shall pay to the affected Medicaid provider a penalty not to exceed one thousand dollars.

2. a. A Medicaid provider who has been denied the provision of a service to a Medicaid member or a claim for reimbursement for a service rendered to a Medicaid member, and who has exhausted the internal appeal process of a managed care organization, shall be entitled to an external independent third-party review of the managed care organization's final adverse determination.

b. To request an external independent third-party review of a final adverse determination by a managed care organization, an aggrieved Medicaid provider shall submit a written request for such review to the managed care organization within sixty calendar days of receiving the final adverse determination.

c. A Medicaid provider's request for an external independent third-party review shall include all of the following:

(1) Identification of each specific issue and dispute directly related to the final adverse determination issued by the managed care organization.

(2) A statement of the basis upon which the Medicaid provider believes the managed care organization's determination to be erroneous.

(3) The Medicaid provider's designated contact information, including name, mailing address, phone number, fax number, and email address.

3. a. Within five business days of receiving a Medicaid

provider's request for an external independent third-party review pursuant to this subsection, the managed care organization shall do all of the following:

(1) Confirm to the Medicaid provider's designated contact, in writing, that the managed care organization has received the request for review.

(2) Notify the department of health and human services of the Medicaid provider's request for review.

(3) Notify the affected Medicaid member of the Medicaid provider's request for review, if the review is related to the denial of a service.

b. If the managed care organization fails to satisfy the requirements of this subsection, the Medicaid provider shall automatically prevail in the review.

4. a. Within fifteen calendar days of receiving a Medicaid provider's request for an external independent third-party review, the managed care organization shall do all of the following:

(1) Submit to the department of health and human services all documentation submitted by the Medicaid provider in the course of the managed care organization's internal appeal process.

(2) Provide the managed care organization's designated contact information, including name, mailing address, phone number, fax number, and email address.

b. If a managed care organization fails to satisfy the requirements of this subsection, the Medicaid provider shall automatically prevail in the review.

5. A request for an external independent third-party review shall automatically extend the deadline to file an appeal for a contested case hearing under chapter 17A, pending the outcome of the external independent third-party review, until thirty calendar days following receipt of the review decision by the Medicaid provider.

6. Upon receiving notification of a request for an external independent third-party review, the department of health and

human services shall do all of the following:

a. Assign the review to an external independent third-party reviewer.

b. Notify the managed care organization of the identity of the external independent third-party reviewer.

c. Notify the Medicaid provider's designated contact of the identity of the external independent third-party reviewer.

7. The department of health and human services shall deny a request for an external independent third-party review if the requesting Medicaid provider fails to exhaust the managed care organization's internal appeal process or fails to submit a timely request for an external independent third-party review pursuant to this section.

8. a. Multiple appeals through the external independent third-party review process regarding the same Medicaid member, a common question of fact, or the interpretation of common applicable regulations or reimbursement requirements may be combined and determined in one action upon request of a party in accordance with rules and regulations adopted by the department of health and human services.

b. The Medicaid provider that initiated a request for an external independent third-party review, or one or more other Medicaid providers, may add claims to such an existing external independent third-party review request following the exhaustion of any applicable managed care organization internal appeal process, if the claims involve a common question of fact or interpretation of common applicable regulations or reimbursement requirements.

9. Documentation reviewed by the external independent third-party reviewer shall be limited to documentation submitted pursuant to subsection 4.

10. An external independent third-party reviewer shall do all of the following:

a. Conduct an external independent third-party review of any claim submitted to the reviewer pursuant to this subsection.

b. Within thirty calendar days from receiving the request for an external independent third-party review from the department of health and human services and the documentation submitted pursuant to subsection 4, issue the reviewer's final decision to the Medicaid provider's designated contact, the managed care organization's designated contact, the department of health and human services, and the affected Medicaid member if the decision involves a denial of service. The reviewer may extend the time to issue a final decision by up to fourteen calendar days upon agreement of all parties to the review.

11. The department of health and human services shall enter into a contract with an external independent review organization that does not have a conflict of interest with the department of health and human services or any managed care organization to conduct the external independent third-party reviews under this section.

a. A party, including the affected Medicaid member or Medicaid provider, may appeal a final decision of the external independent third-party reviewer in a contested case proceeding in accordance with chapter 17A within thirty calendar days from receiving the final decision. A final decision in a contested case proceeding is subject to judicial review.

b. The final decision of an external independent third-party reviewer conducted pursuant to this section shall also direct the nonprevailing party to pay an amount equal to the costs of the review to the external independent third-party reviewer. Any payment ordered pursuant to this subsection shall be stayed pending any appeal of the review. If the final outcome of any appeal is to reverse the decision of the external independent third-party reviewer, the nonprevailing party on appeal shall pay the costs of the review to the external independent third-party reviewer within forty-five calendar days of entry of the final order.

DIVISION VI

MEMBER DISENROLLMENT FOR GOOD CAUSE

Sec. 6. MEMBER DISENROLLMENT FOR GOOD CAUSE. The department of health and human services shall contractually require all Medicaid managed care organizations to issue a decision in response to a member's request for disenrollment for good cause within ten days of the date the member submits the request to the Medicaid managed care organization utilizing the Medicaid managed care organization's grievance process. The department shall adopt rules pursuant to chapter 17A to administer this division.

DIVISION VII

UNIFORM, SINGLE CREDENTIALING

Sec. 7. MEDICAID PROGRAM —— USE OF UNIFORM AUTHORIZATION CRITERIA AND SINGLE CREDENTIALING VERIFICATION ORGANIZATION. The department of health and human services shall develop uniform authorization criteria for, and shall utilize a request for proposals process to procure, a single credentialing verification organization to be utilized in credentialing and recredentialing providers for both the Medicaid managed care and fee-for-service payment and delivery systems. The department or health and human services shall contractually require all Medicaid managed care organizations to apply the uniform authorization criteria and to accept verified information from the single credentialing verification organization procured by the department, and shall contractually prohibit Medicaid managed care organizations from requiring additional credentialing information from a provider in order to participate in the Medicaid managed care organization's provider network.

DIVISION VIII

MEDICAID MANAGED CARE OMBUDSMAN PROGRAM —— APPROPRIATION

Sec. 8. OFFICE OF LONG-TERM CARE OMBUDSMAN —— MEDICAID MANAGED CARE OMBUDSMAN.

1. There is appropriated from the general fund of the state to the department of health and human services office of long-term care ombudsman for the fiscal year beginning July 1, 2025, and ending June 30, 2026, in addition to any other funds

appropriated from the general fund of the state to, and in addition to any other full-time equivalent positions authorized for, the office of long-term care ombudsman for the same purpose, the following amount, or so much thereof as is necessary, to be used for the purposes designated:

For the purposes of the Medicaid managed care ombudsman program including for salaries, support, administration, maintenance, and miscellaneous purposes, and for not more than the following full-time equivalent positions:

..... $ 300,000

..... FTEs 2.50

2. The funding appropriated and the full-time equivalent positions authorized under this section are in addition to any other funds appropriated from the general fund of the state and actually expended, and any other full-time equivalent positions authorized and actually filled as of July 1, 2025, for the Medicaid managed care ombudsman program.

3. Any funds appropriated to and any full-time equivalent positions authorized for the office of long-term care ombudsman for the Medicaid managed care ombudsman program for the fiscal year beginning July 1, 2025, and ending June 30, 2026, shall be used exclusively for the Medicaid managed care ombudsman program.

4. The additional full-time equivalent positions authorized in this section for the Medicaid managed care ombudsman program shall be filled no later than September 1, 2025.

5. The office of long-term care ombudsman shall include in the Medicaid managed care ombudsman program report, on a quarterly basis, the disposition of resources for the Medicaid managed care ombudsman program including actual expenditures and a full-time equivalent positions summary for the prior quarter.

## DIVISION IX

## HEALTH POLICY OVERSIGHT COMMITTEE MEETINGS

Sec. 9. Section 2.45, subsection 5, Code 2025, is amended to read as follows:

5. The legislative health policy oversight committee, which

shall be composed of ten members of the general assembly, consisting of five members from each house, to be appointed by the legislative council. The legislative health policy oversight committee ~~may~~ shall meet at least two times, annually, during the legislative interim to provide continuing oversight for Medicaid managed care, and to ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations.

DIVISION X

MANAGED CARE ORGANIZATIONS —— ANNUAL REPORT ON PROFIT

Sec. 10. MANAGED CARE ORGANIZATIONS —— REPORT ON PROFIT. The department of health and human services shall require each Medicaid managed care organization with whom the department executes a contract under the Medicaid program to annually submit a report by March 1 to the department detailing the profit the managed care organization received from administering Medicaid care during the immediately preceding calendar year, and the methodology used to calculate the profit. The department may select an independent auditor to verify each managed care organization's profit report. The department shall make each managed care organization's report publicly available on the department's internet site.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to the Medicaid program.

Division I of the bill requires the department of health and human services (HHS) to adopt administrative rules to ensure that services are provided to the Medicaid long-term services and supports (LTSS) population in a conflict-free manner. Specifically, the bill requires that case management services shall be provided by independent providers and that the supports intensity scale assessments are performed by independent assessors.

Division II of the bill directs HHS to require each Medicaid

managed care organization (MCO) with whom HHS executes a contract, to provide the option to LTSS population members to enroll in or transition to fee-for-service Medicaid program administration rather than managed care administration. The department shall amend any contract, request any Medicaid state plan amendment, and adopt administrative rules, as necessary, to administer this provision. The rules shall include the process for transitioning a current LTSS population member to fee-for-service program administration.

Division III of the bill directs HHS to require each MCO with whom HHS executes a contract to maintain an authorized member's LTSS unless the member's health care provider determines a change in the LTSS is medically necessary for the member. The inability of a member who is authorized for LTSS to utilize all approved service hours, including respite care, shall not result in a reduction in authorized services unless there is medical evidence that the services are medically unnecessary for the member.

Division IV of the bill requires HHS to contractually require any Medicaid MCO to collaborate with HHS and stakeholders to develop and administer a workforce recruitment, retention, and training program to provide adequate access to appropriate services, including but not limited to services to older Iowans. The department shall ensure that any such program developed is administered in a coordinated and collaborative manner across all contracting MCOs and shall require the MCOs to submit quarterly progress and outcomes reports to HHS.

Division V of the bill establishes an external independent third-party review process for Medicaid providers for the review of final adverse determinations of the MCOs' internal appeals processes. The division provides that a final decision of an external independent third-party reviewer may be reviewed in a contested case proceeding pursuant to Code chapter 17A, and ultimately is subject to judicial review. The bill provides a civil penalty for an MCO that does not comply with the written response requirements relating to an adverse determination.

Division VI of the bill relates to member disenrollment for good cause during the 12 months of closed enrollment between open enrollment periods. The bill requires HHS to contractually require all Medicaid MCOs to issue a decision in response to a member's request for disenrollment for good cause within 10 days of the date the member submits the request to the MCO utilizing the MCO's grievance process and to adopt administrative rules to administer the division.

Division VII of the bill requires the HHS to develop uniform authorization criteria for, and to utilize a request for proposals process to procure, a single credentialing verification organization to be utilized in credentialing and recredentialing providers for the Medicaid managed care and fee-for-service payment and delivery systems. The bill requires HHS to contractually require all Medicaid MCOs to apply the uniform authorization criteria, to accept verified information from the single credentialing verification organization procured by HHS, and to contractually prohibit the MCOs from requiring additional credentialing information from a provider in order to participate in the Medicaid MCO's provider network.

Division VIII of the bill relates to the office of long-term care ombudsman (OLTCO) and the Medicaid managed care ombudsman program (MCOP).

For fiscal year 2025-2026, the bill appropriates $300,000 from the general fund of the state, in addition to any other funds appropriated from the general fund of the state to, and authorizes 2.50 FTEs in addition to any other full-time equivalent (FTE) positions authorized for, HHS for the OLTCO for the purposes of the MCOP. The funding appropriated and the FTE positions authorized under the bill are in addition to any other funds appropriated from the general fund of the state and actually expended, and any other FTE positions authorized and actually filled as of July 1, 2025, for the MCOP.

The bill requires that any funds appropriated to and any full-time equivalent positions authorized for the OLTCO for the

MCOP for fiscal year 2025-2026 shall be used exclusively for the MCOP. The additional FTE positions authorized in the bill for the MCOP shall be filled no later than September 1, 2025.

The bill requires the OLTCO to include in the MCOP report, on a quarterly basis, the disposition of resources for the MCOP including expenditures and an FTE positions summary for the prior quarter.

Division IX amends the provision regarding the meetings of the health policy oversight committee (HPOC) of the legislative council. Current law provides that HPOC may meet annually. The bill provides that HPOC shall meet, and further requires that HPOC meet at least two times, annually, during the legislative interim.

Division X of the bill directs HHS to require each MCO with whom HHS executes a contract to annually submit a report by March 1 to HHS detailing the profit the MCO received from administering Medicaid care during the immediately preceding calendar year, and the methodology the MCO used to calculate the profit. HHS may select an independent auditor to verify each MCO's report. HHS shall make each MCO's report publicly available on HHS's internet site.